2012-13 Governor's Budget: Care Coordination Initiative
Savings Estimates and Methodology

The Department of Health Care Services (DHCS) is committed to improving care coordination for Medi-Cal beneficiaries. This coordinated care initiative aims to improve service delivery for people with Medicare and Medi-Cal— "dual eligible beneficiaries" — and Medi-Cal-only beneficiaries who rely on long-term services and supports (LTSS) to maintain residence in their communities. LTSS includes both home and community-based services (HCBS) and institutional long-term care services (LTC).

Dual eligible beneficiaries represent some of the most expensive and medically complex health cases. The cost for their care is paid for by public funds, including federal funds, state General Fund, and, in some cases, county funds. These individuals will benefit from a care model that provides benefits in a more coordinated manner as opposed to the current fee-for-service model which offers little to no care coordination. Under the coordinated care initiative, a single health plan will generally be responsible for the delivery and coordination of all benefits, including LTSS, which are also currently provided in Medi-Cal fee-for-service and the In Home Supportive Services (IHSS) program. This proposal has benefits for both beneficiaries and the state: it will achieve significant efficiencies, improve care for beneficiaries, enable them to remain in the community rather than in a skilled nursing facility (SNF), and reduce costs from unnecessary hospital and nursing home admissions.

This paper provides the savings methodology for two components of the proposal: 1) a shared savings program in partnership with the federal government for savings generated in the Medicare program from moving dual eligible beneficiaries into managed care; and, 2) the integration of LTSS into Medi-Cal managed care. In addition, the state will save $56.984 million in 2012-13 by aligning managed care policies so that County Organized Health Systems are no longer responsible for the cost of care provided to beneficiaries during their retroactive period. Instead, these costs will be paid through fee-for-service.

Summary of State's Share of Potential Total GF Savings

	2012-13 (six-month period)	2013-14	2014-15	2015-16
Medicare Shared Savings	$ (42,125,000)	$(412,734,000)	$(556,108,000)	$ (651,929,000)
Integrating LTSS	$ (579,669,000)	$(545,833,000)	$(428,915,000)	$ (408,132,000)
Aligning COHS	$ (56,984,000)	$ 7,598,000	$ 7,597,000	$ 7,597,000
Total	$ (678,778,000)	$(950,969,000)	$(977,425,000)	$(1,052,463,000)

In addition, the state will generate increased revenue from the Gross Premium Tax (GPT) as it integrates both dual eligibles and LTSS into Medi-Cal managed care. The Plans will be assessed a GPT on the over $11 billion in revenue for these services and populations which will generate the following additional General Fund savings which will grow in the out years as the amount of revenue that plans receive for these services and populations increases to over $13 billion.

2012-13 (six-month period)	2013-14	2014-15	2015-16
$ (10,702,000)	$ (89,104,000)	$ (149,827,000)	$ (149,827,000)

I. Medicare Shared Savings Program

Summary of State's Share of Potential Savings

2012-13 (six-month period)	2013-14	2014-15	2015-16
$ (42,125,000)	$ (412,734,000)	$ (556,108,000)	$ (651,929,000)

Savings assumptions for this proposal are generally based on DHCS' rate development experience for Medi-Cal-Only Seniors and Persons with Disabilities (SPDs) transitioning from fee-for-service into managed care. However, the assumptions for this proposal are more conservative than the SPD rates and reflect a two-year phase-in of savings for hospital and physician utilization. DHCS assumes 1) managed care plans need time to gain experience with this new Medicare rate structure before they can achieve full savings, 2) a number of months of increased care coordination may need to take place before savings are achieved, and, 3) most of the savings from SNF utilization for this population is reflected in the proposal to integrate LTSS into managed care.

Assumptions:

1. As of July 1, 2011, there were 1,145,634 total Dual Eligibles. It is assumed that enrollment will grow by an annual rate of 1.7%.

2. It is assumed that partial dual eligibles are excluded from the dual eligible demonstration, which constitutes roughly 9.1% of the total dual eligible population, or 104,253.

3. It is assumed that 90% of all full dual eligible beneficiaries will enroll into dual demonstration sites over a three-year period beginning January 2013 and ending December 2015.

4. It is assumed that transition efforts during Year-1 will focus on the ten counties with the greatest dual eligible populations, comprising 74% of the total transition population, or 722,000 beneficiaries. Transition efforts in Year-2 will focus on the remaining managed care counties comprising 16% of the total transition population. Transition efforts in Year-3 will focus on the remaining, primarily rural, fee-for-service counties comprising 10% of the total transition population.

5. It is assumed that inpatient hospital utilization will drop by 15% in SFY 2012-13, 20% in SFY 2013-14, 20% in SFY 2014-15, and 20% in SFY 2015-16.

6. It is assumed that SNF utilization will drop by 5% in SFY 2012-13, 5% in SFY 2013-14, 5% in SFY 2014-15, and 5% in SFY 2015-16. This applies only to those beneficiaries not enrolled in a Long-Term Care aid code.

7. It is assumed that physician utilization will increase by 4% in SFY 2012-13, 5% in SFY 2013-14, 5% in SFY 2014-15, and 5% in SFY 2015-16.

8. It is assumed that pharmaceutical utilization will increase by 2% in SFY 2012-13, 2% in SFY 2013-14, 2% in SFY 2014-15, and 2% in SFY 2015-16.

9. Expenditures presented below include only those incurred by Medicare and excludes Medi-Cal's portion of health care expenditures associated with the dual eligible population.

10. It is assumed that the State will share savings 50:50 with the federal government.

11. Per-Member-Per-Month (PMPM) costs used to derive these estimates were based on five samples of 1,000 beneficiaries from the following aid categories: Aged, Blind, Disabled, Long-Term Care, and all other. The samples were created by matching the Medi-Cal identification numbers for randomly selected beneficiaries to Medicare Part A and Part B claims data. Utilizing the samples created, DHCS developed an estimate of the total Medicare health care costs associated with Medi-Cal's fee-for-service dual eligibles. Because sampling was utilized, some error was expected.

12. DHCS staff did not have access to the Medicare Part D data set; therefore, DHCS staff utilized regression analysis to develop an estimate for Medicare Part D pharmaceutical expenses. By evaluating Medi-Cal pharmacy data for CY 2000 through 2005, DHCS staff was able to determine the PMPM pharmacy expenditures for the dual eligibles within each eligibility category prior to the implementation of Medicare Part D. Based on the trend reflected in this data set, DHCS staff projected the pharmaceutical expenditures, assuming Medi-Cal was paying for this service instead of Medicare.

13. Because DHCS had access to Medicare data through the use of the 2007 sampling file, long-term trends had to be incorporated to develop projections for SFYs 2012-13, 2013-14, 2014-15, and 2015-16. Total Medicare expenditures for this population were assumed to grow by a compound annual growth rate of 6.3% (baseline). Trend rates for each category of service were derived from the Baseline National Health Expenditure Accounts-Aligned MEPS Expenditures - US Civilian Noninstitutionalized Population. These long-term projections are subject to much uncertainty. As with all long-term projections, the further the projection point is beyond the base period, the greater the uncertainty. In addition, because sampling was utilized to develop the 2007 base, sampling error is also a factor that adds additional uncertainty.

14. The Patient Protection and Affordable Care Act (ACA) of 2010 included more than $424 billion in net Medicare spending reductions over a ten-year period, reducing annual payment updates to hospitals and other providers. The impact of these changes was not considered in this analysis.

Table 1 - Transition of Dual Eligibles (Excluding Partial Dual Eligibles) Entitled to Full Medicare Benefits into Care Coordination Demonstration Project Over a Three-Year Period.

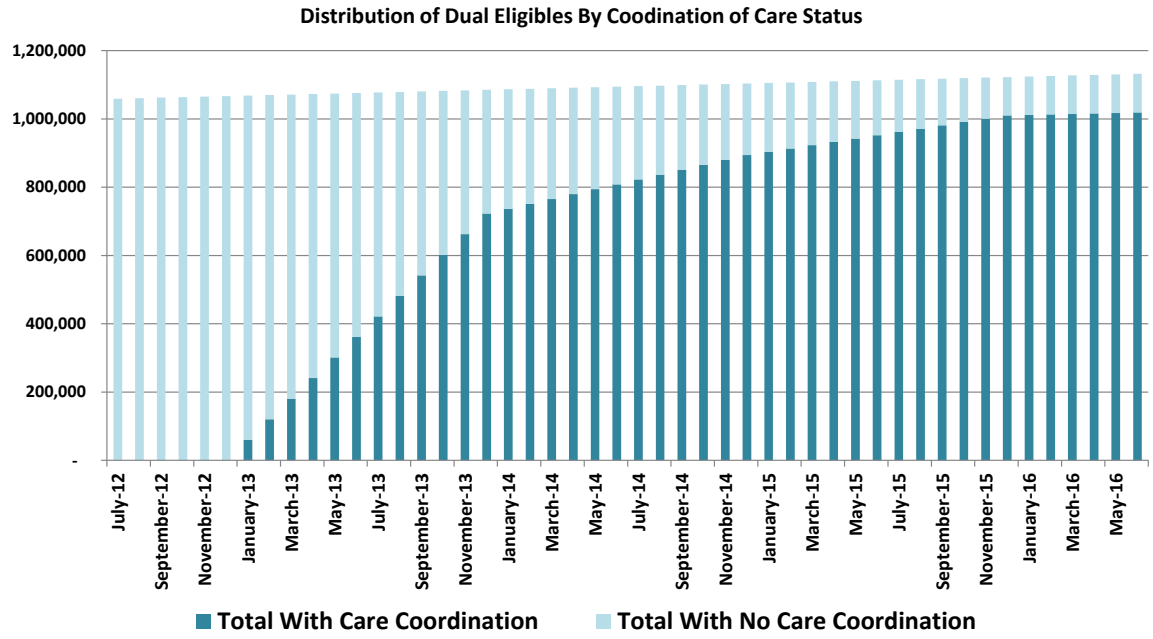

Table 2 - Planned Transition of Dual Eligibles into Coordinated Care Delivery Systems by Fiscal Year and Aid Category; Assumes 90% participation. (member month totals)

Fiscal Year	Aged	Blind	Disabled	Long-Term Care	Other	Total Member Months
FY 2011-12	-	-	-	-	-	-
FY 2012-13	636,215	16,325	502,252	68,961	30,146	**1,253,900**
FY 2013-14	4,059,010	104,153	3,204,332	439,969	192,332	**7,999,796**
FY 2014-15	5,391,561	138,346	4,256,297	584,408	255,472	**10,626,084**
FY 2015-16	6,041,148	155,014	4,769,105	654,819	286,243	**11,906,329**

Table 3– Assumed Change in Utilization by Service Category for Aged, Blind, Disabled, and Other Aid Code Categories (1.0 represents the baseline utilization)

		2012-13	2013-14	2014-15	2015-16
Medicare Part A	Home Health Agency	1.00	1.00	1.00	1.00
	Hospice	1.00	1.00	1.00	1.00
	Inpatient	0.85	0.80	0.80	0.80
	Outpatient	1.00	1.00	1.00	1.00
	Skilled Nursing Facility	0.95	0.95	0.95	0.95
Medicare Part B	Durable Medical Equipment	1.00	1.00	1.00	1.00
	Physician Supplier	1.04	1.05	1.05	1.05
Medicare Part D (Estimated)		1.02	1.02	1.02	1.02

Table 4 - Assumed Change in Utilization by Service Category for Long-Term Care Aid Code Category (1.0 represents the baseline utilization)

		2012-13	2013-14	2014-15	2015-16
Medicare Part A	Home Health Agency	1.00	1.00	1.00	1.00
	Hospice	1.00	1.00	1.00	1.00
	Inpatient	0.85	0.80	0.80	0.80
	Outpatient	1.00	1.00	1.00	1.00
	Skilled Nursing Facility	1.00	1.00	1.00	1.00
Medicare Part B	Durable Medical Equipment	1.00	1.00	1.00	1.00
	Physician Supplier	1.04	1.05	1.05	1.05
Medicare Part D (Estimated)		1.02	1.02	1.02	1.02

Table 5- Total Expenditures Assuming No Change By Service Category (based on phase-in)

Health Service Category		Without Change In Utilization Factors			
		2012-2013	2013-14	2014-15	2015-16
Medicare Part A	Home Health Agency	$ 83,113,311	$ 563,491,774	$ 793,208,092	$ 937,201,051
	Hospice	$ 25,826,439	$ 174,807,555	$ 239,287,250	$ 276,101,318
	Inpatient	$720,559,788	$4,801,083,187	$6,661,783,007	$7,807,529,807
	Outpatient	$197,446,004	$1,328,785,644	$1,840,014,017	$2,162,052,473
	Skilled Nursing Facilty	$ 137,841,545	$ 932,986,764	$1,277,129,397	$1,473,614,380
	subtotal	$1,164,787,087	$7,801,154,925	$10,811,421,763	$12,656,499,029
Medicare Part B	Durable Medical Equipmemt	$ 56,720,637	$ 383,915,745	$ 525,527,440	$ 606,379,052
	Physician Supplier	$ 364,950,664	$2,395,857,844	$ 3,265,579,216	$ 3,769,437,971
	Subtotal	$ 421,671,301	$ 2,779,773,589	$ 3,791,106,656	$ 4,375,817,023
Medicare Part D (Estimated)		$ 526,330,063	$ 3,586,095,992	$ 5,061,856,905	$ 6,018,922,416
GRAND TOTAL		**$2,112,788,450**	**$14,167,024,507**	**$19,664,385,324**	**$23,051,238,469**

Table 6 – Total Expenditures Following Change By Service Category (based on phase-in)

Health Service Category		With Change In Utilization Factors			
		2012-2013	**2013-14**	**2014-15**	**2015-16**
Medicare Part A	Home Health Agency	$83,113,311	$563,491,774	$793,208,092	$937,201,051
	Hospice	$25,826,439	$174,807,555	$239,287,250	$276,101,318
	Inpatient	$614,075,926	$3,832,305,608	$5,329,426,405	$6,246,023,846
	Outpatient	$197,446,004	$1,328,785,644	$1,840,014,017	$2,162,052,473
	Skilled Nursing Facility	$133,051,959	$898,620,040	$1,232,754,830	$1,422,412,843
	subtotal	$1,053,513,638	$6,798,010,621	$9,434,690,594	$11,043,791,531
Medicare Part B	Durable Medical Equipment	$56,720,637	$383,915,745	$525,527,440	$606,379,052
	Physician Supplier	$381,448,343	$2,510,225,935	$3,428,858,177	$3,957,909,870
	subtotal	$438,168,980	$2,894,141,680	$3,954,385,617	$4,564,288,922
Medicare Part D (Estimated)		$536,855,833	$3,649,403,247	$5,163,094,044	$6,139,300,865
GRAND TOTAL		**$2,028,538,451**	**$13,341,555,548**	**$18,552,170,254**	**$21,747,381,317**

Table 7 - Overall Difference in Expenditures By Service Category; Status Quo Compared to Proposed Increases in Care Coordination and other Changes

Health Service Category		Difference			
		2012-2013	2013-14	2014-15	2015-16
Medicare Part A	Home Health Agency	$-	$-	$-	$-
	Hospice	$-	$-	$-	$-
	Inpatient	$(106,483,862)	$(968,777,580)	$(1,332,356,601)	$(1,561,505,961)
	Outpatient	$-	$-	$-	$-
	Skilled Nursing Facility	$(4,789,587)	$(34,366,725)	$(44,374,567)	$(51,201,537)
	subtotal	$(111,273,448)	$(1,003,144,304)	$(1,376,731,169)	$(1,612,707,499)
Medicare Part B	Durable Medical Equipment	$-	$-	$-	$-
	Physician Supplier	$16,497,679	$114,368,091	$163,278,961	$188,471,899
	subtotal	$16,497,679	$114,368,091	$163,278,961	$188,471,899
Medicare Part D (Estimated)		$10,525,770	$63,307,255	$101,237,138	$120,378,448
GRAND TOTAL		**$(84,249,999)**	**$(825,468,959)**	**$(1,112,215,070)**	**$(1,303,857,152)**

Table 8 - State Share of Potential Savings Assuming 50% Split By Service Category Category

Health Service Category		State Share			
		2012-2013	2013-14	2014-15	2015-16
Medicare Part A	Home Health Agency	$-	$-	$-	$-
	Hospice	$-	$-	$-	$-
	Inpatient	$(53,241,931)	$(484,388,790)	$(666,178,301)	$(780,752,981)
	Outpatient	$-	$-	$-	$-
	Skilled Nursing Facility	$(2,394,793)	$(17,183,362)	$(22,187,284)	$(25,600,769)
	subtotal	$(55,636,724)	$(501,572,152)	$(688,365,584)	$(806,353,749)
Medicare Part B	Durable Medical Equipment	$-	$-	$-	$-
	Physician Supplier	$8,248,840	$57,184,046	$81,639,480	$94,235,949
	subtotal	$8,248,840	$57,184,046	$81,639,480	$94,235,949
Medicare Part D (Estimated)		$5,262,885	$31,653,627	$50,618,569	$60,189,224
GRAND TOTAL		**$(42,125,000)**	**$(412,734,479)**	**$(556,107,535)**	**$(651,928,576)**

II. Integrating into Managed Care Medi-Cal Funded Long Term Services and Supports

DHCS proposes to consolidate responsibility for all Medi-Cal funded medical and long-term services and supports (LTSS) into Medi-Cal managed care. LTSS includes: 1) home and community-based services (HCBS), such as services provided through the In-Home Supportive Services (IHSS) program, Community-Based Adult Services (CBAS), and services provided through the Multi-purpose Senior Services Program (MSSP), and 2) institutional long-term care (LTC) services, such as services provided in skilled nursing facilities (SNFs). Coordinating beneficiaries' care through the managed care system creates significant savings opportunities by reducing high-cost institutional and long-term care services through the increased use of LTSS and preventive care provided through primary health care providers.

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Summary of State's Share of Potential GF Savings

2012-13 (six-month period)	2013-14	2014-15	2015-16
$ (579,669,000)	$ (545,833,000)	$ (428,915,000)	$ (408,132,000)

For 2012-13, because the Medi-Cal program is financed on a cash versus accrual basis, there will be overlapping payments for prior services provided in FFS and managed care capitation payments. Without these overlapping payments, this proposal would generate GF savings of $30,375,006 in 2012-13; however, the overlapping payments result in a one-time GF cost in 2012-13 of $166,208,000. To address the overlapping payments, one managed care payment and one checkwrite will be deferred, resulting in one-time GF savings of $745,876,000.

All 1.1 million dual eligibles and 160,000 Medi-Cal Only Seniors and Persons with Disabilities who use LTSS were included in this analysis. The assumption is that the dual eligibles' Medi-Cal benefits (primarily LTSS) and the LTSS benefits for the SPDs will be phased in starting January 2013 with one 1/12 phased in per month. The phase in will be completed by December 31, 2013.

In calculating the anticipated savings for implementation of this proposal, 2010 FFS data was examined for beneficiaries that met specific criteria. Eligibility and cost data was trended forward from the study period. Various savings factors were applied based on previous experience with managed care populations shifting from the FFS environment, including data from other states such as Arizona and Tennessee. Major changes after integration include:

- Inpatient and long-term care institutional services will be reduced by, respectively, 22.4% and 11.7% in year 1. IHSS, CBAS, and other HCBS will increase by 6.1% in the first year and then will level off at a 2.3% per year increase in FY 2015-16.
- Overall, savings as percentages of the projected FFS costs are estimated to be about 3.2% in FY 2012-13 and 6.1% in FY 2015-16.

Below we will discuss: 1) the FFS base data and adjustments made to the base data; 2) managed care savings factors; and, 3) trend.

1) Base Data and Adjustments

DHCS based the analysis on 2010 FFS data (date of service in 2010 paid through September 2011). Beneficiaries included in the data meet the following three conditions: 1) dual eligibles or Medi-Cal only eligibles that received LTSS; 2) enrolled in managed care plan covered aid codes; 3) reside in managed care counties. All FFS costs associated with those beneficiaries were included in the analysis with the following adjustments:

1. 2% of Incurred But Not Reported (IBNR) inpatient hospital claims were added to the base data. Other claims were assumed completely paid and reflected in the base data.
2. Intermediate Care Facilities for the Developmentally Disabled (ICFDD) services were excluded.
3. It is assumed that all the Medi-Cal only SPD eligibles will be enrolled in Two-Plan/Geographic Managed Care (GMC) plans by the time of the LTSS integration. So only the calculated carve-out costs of the Medi-Cal only SPD eligibles, including institutional LTC, were included in the analysis.
4. Provider payment reductions specified in AB 97.

For the new COHS counties in the analysis, institutional LTC is already included in the rates to the plans and was not included in this analysis.

2) Managed Care Saving Factors

Mercer's managed care saving factors used in Mercer's SPD rating model were applied in this analysis for all the service categories covered by the Two-Plan/GMC plans (including institutional LTC in the first two months). Those managed care saving factors were offset by 4% of the assumed admin/profit margin.

For the service categories currently not covered by the Two-Plan/GMC model – institutional LTC after two months (LTC+2) and HCBS (together, LTSS), the following assumptions are used:

- In the first year of the integration, managed care plans will achieve 8.8% of savings on institutional LTC+2. This assumption is made with reference to Tennessee's TennCare Choices' budget for its nursing home care. Nursing home care and home/community based services were integrated into managed care in Tennessee in the middle of 2010. Its budget for nursing home care in 2011 decreased 12.5% from the previous year's, which included a 4.25% provider rate reduction. Excluding the provider rate reduction, TennCare Choices' budget for nursing home care decreased by 8.8%.

- In addition, institutional LTC for 1-2 months will decrease by 56.3 percent making the overall reduction in institutional LTC for all months at 11.7 percent.
- The savings on LTC+2 will be realized by increasing the use of HCBS services. Overall, no managed care savings for the two service categories as a whole are assumed in the first year of the integration. As a result, managed care plans' expenditures on HCBS will increase by 6.1% compared with FFS.

The following table shows the 2010 adjusted FFS costs, savings based on the 2010 adjusted FFS costs, and savings as percentages of the 2010 adjusted FFS costs for each of the service categories:

Table 9- Categories of Services and Related FFS Costs and Savings for 2010

Categories of Services	2010 Adj. FFS Costs	Savings	Savings %
Inpatient Hospital	730,576,266	163,811,326	22.4%
Outpatient Facility	60,559,617	10,357,375	17.1%
Emergency Room	976,948	221,129	22.6%
Long-Term Care 1 - 2 Months	217,768,954	122,632,268	56.3%
Long-Term Care > 2 Months	3,411,713,606	300,445,455	8.8%
Physician Primary Care	51,645,492	-8,987,095	-17.4%
Physician Specialty	73,872,154	-3,773,029	-5.1%
FQHC	113,575,244	13,499,098	11.9%
Other Medical Professional	20,910,377	-5,816,661	-27.8%
Pharmacy	449,891,977	43,171,929	9.6%
Laboratory and Radiology	4,438,836	-332,661	-7.5%
Transportation	79,517,149	18,892,536	23.8%
HCBS (primarily IHSS)	4,888,437,980	-300,445,455	-6.1%
All Others	1,551,628,654	15,152,624	1.0%
Total	11,655,513,252	368,828,837	3.2%

The table shows that total 2010 adjusted FFS costs are $11.7 billion and the savings are estimated at $369 million annually, or about 3.2% of the adjusted FFS costs. Based on the 12 month phase-in, the savings are estimated to be $30,513,833 in 2012-13 (on an accrual basis). Major savings are in the categories of inpatient hospital and the first two months of institutional LTC services. The savings in institutional LTC after two months are exactly offset by the cost increase in the HCBS category which primarily includes IHSS. It should be noted that results reported in the above table are based on the assumption of immediate implementation of the integration and full enrollment. While it shows the magnitude of the current FFS expenses by service category and where savings are expected to come from, no trend was incorporated in the calculation.

3) Trend

Three types of trends were applied in the analysis.

1. Eligibility – It is assumed that the eligibles will increase 1.7% per year.
2. Per member average costs – Mercer's trend factors for per member average costs were used in the analysis for the Two-Plan covered service categories. No trend was assumed for LTC and HCBS. Overall, the averaged costs are projected to increase about 0.8% percent. Combined the trends in eligibles and average costs, the total costs are projected to increase about 2.5% per year.
3. Managed care saving factors – Mercer has two years managed care saving factors used in its SPD rating models. Those factors are applied in this analysis for the first two years of the implementation of the project. It is assumed one half of the improvement in the second year over the first year will be realized in the third year. For example, if the factor is 22% in the first year and 24% the second year (a difference of 2%), the factor for the third year is calculated at 25% (24% plus one half of 2%). The factors used in the third year remain the same in the fourth year. For the service categories of LTC after two months and HCBS, as a whole, zero savings were assumed in the first year of the implementation of project (2013), 2% of savings in the second year, 2.5% in the third year, and 3% in the fourth year. Savings on LTC+2 are assumed to increase from 8.8% in FY 2012-13 to 10.1% in FY 2015-16. As a result, the expenses of HCBS under managed care will be about 2.3% higher than the projected FFS expenses.

The following table shows the FY 2015-2016 projected FFS costs, savings, and savings as percentages of the projected FFS costs for each of the service categories. It shows that savings are estimated to be about 6.1% of the projected FFS costs and LTC will become the leading service category for savings.

Table 10- Categories of Services and Related FFS Costs and Savings for FY 2015-2016

Categories of Services	Projected FY 2015-2016 FFS Costs	Projected FY 2015-2016 Savings	Savings %
Inpatient Hospital	1,034,566,974	296,518,817	28.7%
Outpatient Facility	90,555,524	18,071,386	20.0%
Emergency Room	1,516,020	462,616	30.5%
Long-Term Care 1 - 2 Months	238,924,786	143,918,458	60.2%
Long-Term Care > 2 Months	3,743,154,977	376,422,586	10.1%
Physician Primary Care	59,970,095	(17,280,443)	-28.8%
Physician Specialty	87,408,539	(3,707,371)	-4.2%
FQHC	133,556,198	15,873,954	11.9%
Other Medical Professional	24,486,163	(8,241,961)	-33.7%
Pharmacy	610,773,339	71,606,515	11.7%
Laboratory and Radiology	5,154,321	(386,282)	-7.5%
Transportation	131,244,926	31,182,575	23.8%
HCBS (primarily IHSS)	5,363,340,265	(125,993,967)	-2.3%
All Others	1,824,508,485	17,817,466	1.0%
Total	**13,349,160,612**	**816,264,349**	**6.1%**